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Infant Eczema: Diagnosis, Treatment, and Parent Education

Announcer:

You're listening to *On the Frontlines of Pediatric Skin Health* on ReachMD. Here's your host, Dr. Mary Leuchars.

Dr. Leuchars:

This is *On the Frontlines of Pediatric Skin Health* on ReachMD. I'm Dr. Mary Leuchars, and joining me to unpack the unique challenges of recognizing and managing atopic dermatitis in infants is Dr. Mariam Iqneibi. She's a pediatric dermatologist at Cincinnati Children's Hospital and an Assistant Professor of Dermatology at the University of Cincinnati College of Medicine.

Dr. Iqneibi, we're so happy to have you. Welcome to the program.

Dr. Iqneibi:

Thank you all for having me. This is an exciting and important topic, atopic dermatitis. Especially in infants, I feel like there's a lot of confusing things out there and a lot of misleading information, so I'm excited that we're having this discussion.

Dr. Leuchars:

Excellent. So let's start with the big picture, Dr. Iqneibi. What causes atopic dermatitis to develop in infants, and what is it about a baby's skin that makes it more vulnerable than an adult's?

Dr. Iqneibi:

Like most things in medicine, it's a combination of factors. So usually, in infantile atopic dermatitis, one factor is the barrier dysfunction. So you have a dysfunction in the skin barrier, and that can be due to a lot of things.

One is, of course, the environment. So the weather plays a role. That's why certain people tend to flare during winter seasons—the colder, drier weather—versus the summer.

Another factor is that babies naturally have thinner skin, so that also makes their barrier a little bit more impaired. They have a larger body surface area ratio, so that, of course, also causes them to be more vulnerable to developing irritation or immune reactions to environmental factors or topical agents.

So all these things combined can cause the skin not to hold onto moisture as effectively and become more permeable to different types of irritants and allergens.

The other component of eczema is an immune dysregulation. So when your skin barrier is not functioning the way it's supposed to, anything can get through the skin and cause your immune system to rile up. And we know that eczema is mainly a Type 2 hypersensitivity reaction. This immune dysregulation also further worsens the barrier dysfunction and also worsens the itching. And of course, if you have itch, you will rub your skin, and that also, in itself, helps to produce the cycle and continue it further.

There's also a genetic component, so it's really important to ask about family history of atopy. So this goes not only to eczema. You also have to ask about things like, is there a family history of asthma, nose allergies, or eye allergies? You have to ask about things that could raise red flags for eosinophilic esophagitis in the babies, because, again, they're type 2 hypersensitivity reactions. And if you are genetically predisposed to have a type 2 hypersensitivity dysfunction, then you are more likely to develop eczema.

The other thing is that babies get exposure to a lot of irritating factors in their skin that I think sometimes we forget to ask about. So it's always important to ask about things like, what wipes are we using? Does eczema tend to flare around the mouth? Then you have to think about saliva. Fragranced products, use of botanical ingredients—all these things can also irritate the skin.

So just to summarize, it's a combination of barrier dysfunction, immune dysregulation, and genetic factors, as well as exposure to different irritating and aggravating agents.

Dr. Leuchars:

That's a great clinical summary. And are there any specific genetic mutations that make them more vulnerable?

Dr. Iqneibi:

We do know that filaggrin mutation is the most famous. So if you have a filaggrin mutation, you're more likely to develop atopic dermatitis. We know that there are certain immunodeficiency disorders that can cause you to be vulnerable to reducing eczema. We know that there are different types of ichthyoses, which can also cause you to be more predisposed to developing eczema.

Because again, you're talking about conditions that either affect the immune system or affect the skin barrier's production or proper functioning. So if you are having insufficiency or overactivity in the immune system, then you are more likely to develop eczema.

Dr. Leuchars:

So when an infant presents with a rash, what are the clues that help you recognize atopic dermatitis early, and what can make diagnosing it challenging?

Dr. Iqneibi:

One clue is, of course, the distribution. So typically, when we think of eczema, we think of adult site eczema, correct? We think of flexural areas. We think of the elbow creases, we think of behind the knees. That's not usually the case in infants. So in infants, it's actually the opposite. It's more on the extensor aspect of the extremities. So that's one clue.

Now, how does eczema present? It presents as these dull red, very ill-defined scaly patches or plaques that obviously look very dry. And again, we mainly see it in infants on the scalp. I also see it on the cheek, and I do think that around the mouth, part of it is due to irritation from saliva, especially if they're particularly drooly.

The neck, the arms, the lower legs—those are your predilection sites. Now, what makes it challenging, particularly, I would say, in the infant population versus others, is that infants are not able to communicate, right? One of the main diagnostic factors for eczema is itch. Eczema is famous for its itch. But you can't really tell that in an infant sometimes. It's quite difficult, because they don't develop a full, proper itch-scratch response until above the age of six months.

So I like to ask about different clues that mean they're itching. So for infants, what I tend to see is that they'll rub their faces or their bodies against their family or other objects. So that's one clue that you know that the baby is itchy. The other clue is that they'll sometimes rub their legs together. So that is also an itch response. And I'll also ask about their sleep. Does it seem that they're very irritable during sleep? Are they wiggling a lot during sleep? Because the wiggling is the way they scratch their back.

So those things do make it challenging, but there are clues that are important to ask about, because again, these babies don't have a proper itch-scratch reflex.

The other thing I like to ask about to help me diagnosis is the history. Certain clues include, when did this start? How has it evolved? If it's a chronic relapsing nature, then that also goes particularly with eczema. I ask about what products are being used on the baby. If there is a lot of use of irritative products, that also makes me think, hmm, this could be a contact dermatitis with associated eczema. I ask about family history of atopic dermatitis, because that also provides me with a clue that this could possibly be eczema.

But again, it is quite difficult. The one thing that I will say that I frequently see occurring with eczema is sometimes it's difficult to differentiate between that and seborrheic dermatitis. And that's basically caused by a yeast called *Malassezia*, and it also presents on the scalp. And we do have eczema on the scalp that can appear in babies, but that presents with a more yellow, greasy sort of scale. So that's the cradle cap that we classically know. The other thing that sometimes is difficult to differentiate is psoriasis. That can be a little bit tricky, especially at this age, because that tends to occur also in the diaper areas. But it is quite rare. Scabies is another thing that could be confusing because it's also very itchy, particularly at night, like eczema. And it can occur on the scalp, as well.

I think looking at all these pieces together will help lead you towards the diagnosis.

Dr. Leuchars:

For those of you just tuning in, you're listening to *On the Frontlines of Pediatric Skin Health* on ReachMD. I'm Dr. Mary Leuchars, and I'm speaking with Dr. Mariam Iqneibi about diagnosing and managing atopic dermatitis in babies.

So, Dr. Iqneibi, how do you effectively build a treatment plan that's also realistic for parents to follow?

Dr. Iqneibi:

So it's a shared decision-making. I try to see what they're using, what they're comfortable with using, and why they're not comfortable using certain other products. And it's a discussion.

So I always, first of all, explain. I think it's very important to educate parents properly on what eczema is, because they'll come to you already frustrated.

They'll be like, "I've already tried moisturizers. I've already tried thousands of different moisturizers. I've already tried mild topical steroids, and none of them work." It's important to go back to explaining the barrier dysfunction—saying there is a barrier dysfunction here, and that the skin is not functioning the way it should, where it's a wall that's protecting you from the outside world. So you need to help restore that wall to its proper function.

And how are you going to do that? You're going to do that with bland moisturizers. So we need a bland moisturizer, something that is fragrance-free and does not contain irritative components—preferably a cream or ointment-based moisturizer. And I do explain to them why, which is because those types of moisturizers help to retain the water better and moisturize the skin better. So that's the first step. Moisturize, I would say, anywhere from two to four times a day. I try to tell them to get into a habit of, with every diaper change, just moisturizing their baby down, as well as after a shower, if feasible.

So that's part one. The other part is I also explain the inflammation component. I say, there's immune dysfunction here. That's all that redness that you're seeing. That's the immune system riling up. How are you going to treat that? You're going to treat that with products that are going to calm the immune system down. What are these products? So these products are topical steroid agents, and we have different strengths for steroids. So we have the mild strength of steroids, we have the moderate strength of steroids, and we have the very strong steroids.

And there's a lot of steroidphobia, I feel, out there, and a lot of concern for tachyphylaxis, so I really try to have a deep discussion about how everything in life is good in moderation. Of course, you don't want to use things excessively. So just have that discussion of how to use steroids properly, how long to use steroids, when to be concerned about the overuse of steroids, and how much of these topical steroids are realistically going to cause systemic absorption, which is very, very rare in moderate to mild potency topical steroids.

But just I think having that discussion early on helps parents understand what topical agents are available. And also, I like to offer, for parents who do not like topical steroid agents, non-steroidal agents. So we have a lot of non-steroidal agents available on the market. We have topical calcineurin inhibitors and we have topical phosphodiesterase inhibitors that can all help to also calm the immune system down. And what's really fantastic is that we also have biologic agents that are approved for six months of age and older, which also helps to specifically target the part of the immune system that causes eczema niche, so the IL-4 and the IL-13.

I have that discussion with parents. I put all options on the table. I'm like, "What is recommended is usually topical steroid agents, and we're going to use it in this way. In this way, when we use it in these ways, we're unlikely to get systemic absorption or any steroid side effects." I also like to offer non-steroidal agents, especially in mild eczema or in sensitive sites like the like the face, the underarms, and the diaper area.

And in severe cases, just because I know it's tiring to put steroids all over the body, or maybe they're not getting the response that they wanted from these topical agents, then I like to have that discussion about systemic therapy.

Dr. Leuchars:

For those parents who are worried about the name of the diagnosis or the actual diagnosis, what do you initially say to reassure them, aside from the things that you already discussed?

Dr. Iqneibi:

So I just say that this is eczema, you know? This is just childhood eczema, and most babies grow out of their eczema. And we do see this commonly, and it is frustrating. I do talk to them and say I understand. It is frustrating because you'll have days where you're doing all the right steps and the eczema's still there, and then you'll have days where the eczema's gone.

So I really try to discuss with them that it's a lifestyle, so you have to make sure that you're not exposing your baby to any irritative components that could worsen their skin. When you know the triggers—for example, the weather—and if you know that your baby tends to get worse in winter weather, then you want to up the moisturizing routine.

I try to also explain how to use proactive therapy. That's something else that I think is a really important discussion. If you know your baby gets eczema on certain sites of the body, then you want to proactively treat those sites twice a week. So on two days a week, any two days a week, twice a day, proactively treat those sites, because you want to prevent the immune system from riling up in those sites.

So when I have that discussion with parents, when they know they also have a future plan to prevent, I think they tend to be more willing to try and to use the topical agents and to use this therapy.

Dr. Leuchars:

So before we come to the end of our program, Dr. Iqneibi, do you have any final takeaways you'd like our audience to keep in mind?

Dr. Iqneibi:

Yeah, I just want to reassure the physicians and parents that are dealing with this, because it's very frustrating on all ends. We want to see our patients get completely better, and we want to see the parents completely happy with the progress of their baby's results.

But it's chronic. It's recurring. It does require a little bit of trial and error, but it's mainly just to discuss the lifestyle approach, emphasize the moisturizing routine, emphasize the safety and the different types of anti-inflammatory agents that we could use. And just emphasize that this is something that most likely, more than not, will go away with time.

So I think when parents hear that, they're like, "Okay, we can get through this."

Dr. Leuchars:

Well, that's a great way to round out our conversation. I want to thank my guest, Dr. Mariam Iqneibi, for sharing her perspective on how we can support infants and families with atopic dermatitis. Dr. Iqneibi, it was really great having you here today. Really appreciate all your insights and expert opinions.

Dr. Iqneibi:

Thank you. I really enjoyed this conversation. And yeah, thank you all for having me on.

Announcer:

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